EXHIBIT 22

Re: Disability Letter

We are in receipt of information from your employer indicating that you stopped working because you are disabled. In order for your health coverage to continue, we must have the proof of your disability statement below completed by your attending physician.

The completed form should be mailed or faxed to Railroad Enrollment Services. The mailing address and fax number are:

Railroad Enrollment Services
PO Box 30775
Salt Lake City, UT 84130-0775
Fax #: (248) 733-6080

IF THIS PROOF OF DISABILITY IS NOT RECEIVED, YOUR COVERAGE WILL BE TERMINATED.

If you have questions, please call Railroad Enrollment Services at (800) 753-2692.

EID # 404809

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Please put ssn here:
612-09-2096

I certify that Jacob Goss has been disabled from performing his/her regular occupation from _____ (Date) to permanent (Date) due to the following condition(s):
Color Vision Defect, released to return to work with permanent restrictions. unable to be accommodated.

Is the employee permanently disabled from his/her regular occupation? (YES) NO
(Please circle one.)

If no, please give us an estimated return to work date _____, or

the date of his/her next appointment with you NA

Joan P Holland MD MPH 5-25-2016
Physician's Signature (JL) Date

I AM NOT THE TREATING PHYSICIAN. THIS FORM COMPLETED IN MY CAPACITY AS MEDICAL DIRECTOR FOR THE UNION PACIFIC RAILROAD.

MD0885